COMPLIANCE PEER REVIEW

N. A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary

February 2008

Table

STUDENT ENROLLMENT

Division of Juvenile Justice Education Manual, Sections 4065-4067, and Subsection of the California Education Authority Section III (b)

Office of Audits and Compliance Staff
George Valencia, Youth Authority Administrator

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EXECUTIVE SUMMARY

The Office of Audits and Compliance (OAC), Compliance Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ) Education Manual, Sections 4065-4067, and sub-sections of the California Education Authority (CEA) Section III (b), to determine whether the school at N.A. Chaderjian Youth Correctional Facility (NACYCF) was in compliance with the policies stating that students are to be enrolled into an appropriate educational program within four days of arrival to his/her assigned facility.

The review period was August 1, 2007 through January 31, 2008. During this period, it was determined that N. A. Chaderjian School (NACS) had a total of 169 wards that did not have their high school diploma or their General Education Certificate. There were three categories of students; English Learner, Special Education and General Education. The CPRB selected six student records in the Ward Information Network (WIN) from each of the categories, totaling a sample of 18 student records, (approximately 10 percent) to be reviewed from the educational portion of the WIN.

The principal, primary school scheduler, secondary school scheduler, school registrar and the curriculum specialist were all interviewed to gain an understanding of the student enrollment process.

The CPRB determined that overall the school is not in compliance with the DJJ Education Manual, Sections 4065-4067, as it pertained to the principal having a written procedure in place to ensure students are assigned to the appropriate educational program based on their High School Graduation Plan, (YA) DJJ 7.423, and/or Personal Education Plan, DJJ 7.102, and their need for supplementary services within four days of arrival to his/her assigned facility.

Of the 18 records reviewed in the WIN, the CPRB found that NACS was in full compliance with the CEA Section III (b) policy declaring that students are to be enrolled into an appropriate educational program within four days of arrival to his/her assigned facility.

BACKGROUND

The CPRB met with James Cripe, Acting Deputy Director of Education for the DJJ on December 20, 2007. The purpose of the meeting and subsequent meetings with the Division of Juvenile Justice Education Department (DJJED) was to discuss the peer review process, to identify high risk areas, and evaluate the highest risk areas during the peer review. Based on risk factor, it was determined by the CPRB that student enrollment within four days of arrival to his/her assigned facility would be reviewed.

This area was selected by the CPRB because students that are not high school graduates are mandated to be enrolled in school per the DJJ Educational Manual, Sections 4065-4067, and the CEA Section III (b). Additionally, student enrollment within four days has been a problem area for DJJ schools in the past.

The specific objectives of the review were to determine whether:

- NACS is enrolling students in classes within four days of arrival to his/her assigned facility.

- NACS has a written educational operating policy to address student enrollment within four days of arrival to his/her assigned facility.

FINDINGS AND RECOMMENDATIONS

FINDING 1: There are no written procedures in place to ensure that students are enrolled within four days of arrival to his/her assigned facility.

The CPRB conducted several interviews during the period of February 25 through February 27, 2008 with the principal of NACS, school schedulers, and the DJJED curriculum development coordinator to determine if there were any written procedures in place to address student enrollment. From the numerous interviews, it was determined that there are no written procedures that could be used to train the school scheduler to address student enrollment. Acknowledgement was made by the school principal and the DJJED curriculum development coordinator that there are no written procedures relating to the four day enrollment at NACS.

The education department at NACS is operating off Temporary Departmental Orders in the DJJ Educational Manual, Sections 4065-4067, that address student enrollment. The CPRB reviewed this section and interviewed the DJJED curriculum development coordinator and the principal of NACS for further clarification on the policy. The DJJED curriculum development coordinator agreed that the policy about student enrollment within four days of arrival to his/her assigned facility was unclear.

According to the primary school scheduler, he adheres to the following procedure to ensure student enrollment within four days of arrival to his/her assigned facility: The school scheduler receives an institutional daily movement roster summary which depicts wards that have arrived and departed from the institution, as well as intra-facility transfers. The school scheduler queries the WIN to print a daily transfer report and produces a list of all wards assigned to the NACYCF facility daily. From that query, the school scheduler sorts the list to determine what wards need to be placed in school to meet the four day enrollment requirement.

The last school scheduling training the primary scheduler received was on October 26, 2007. The primary scheduler received his initial scheduling training through fellow education staff. The primary scheduler was not given any written procedures on how to schedule students within four days of arrival to his/her assigned institution. All procedures on the process of enrolling students within four days of arrival to his/her assigned facility were given orally.

Criteria:

According to the DJJ Education Manual, Section 4065-4067, Temporary Departmental Order, revision ET-13 states the following: "The Principal shall have a written procedure in place to ensure students are assigned to the appropriate education program based on their High School Graduation Plan, (YA) DJJ 7.423, and /or Personal Plan, DJJ 7.102, and their need for supplementary services within four school days of arrival to his/her assigned facility."

Further the Education Service Branch of the CEA states the following in Section III (b) of the Student Access Attendance: "As students arrive at CEA high schools, they are assessed and enrolled into appropriate educational programs within 4 school days of their arrival."

Recommendation:

- Establish a clear policy in the DJJ Education Manual on student enrollment within four days of arrival to his/her assigned facility.

- NACS shall develop a written operational procedure on student enrollment within four days of arrival to his/her assigned facility.

- Finalize the policy on student enrollment within four days of arrival to his/her assigned facility.

COMPLIANCE PEER REVIEW

N. A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary

March 2008

HEALTH CARE SERVICE REQUEST FORMS

Institutions and Camps Manual, Section 6249.9 (Revision IT-46), and 6255

Office of Audits and Compliance Staff
Karen Jennings, Team Treatment Supervisor

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Institution and Camps Branch Manual (I&C Manual), Sections 6249.9, Revision IT-46, and 6255 to determine if N. A. Chaderjian Youth Correctional Facility (NACYCF) is in compliance with the policy that identifies the responsibilities of health care staff for treating, evaluating, and tracking wards that request mental health services by submitting a Health Care Service Request form, Division of Juvenile Justice (DJJ) 8.018.

The review period was August 1, 2007 through January 23, 2008. During this period, the CPRB reviewed the Health Care Service Tracking log and found a total of 94 Health Care Service Requests submitted by wards in need of mental health services. The CPRB sampled 10 percent of the wards requesting mental health services. Therefore, 9 wards and their Unified Health Records (UHR) were selected to be reviewed. Of the 9 wards selected, 4 submitted multiple requests. As a result, the CPRB reviewed 9 UHRs and 16 Health Care Service Request forms.

The CPRB determined that NACYCF is not in compliance with the I&C Manual, Sections 6249.9, Revision IT-46, and 6255. The following were the findings:

- 12 out of the 16 (75 percent) Health Care Service Request forms submitted had no documentation by clinical staff that the wards requesting services were evaluated.

- 12 out of 16 (75 percent) Health Care Service Request forms were not in the UHRs. Consequently, there were only four Health Care Service Request Forms that could be reviewed in the UHR.

- One of the four (25 percent) records of assessments completed by the psychologist was documented on the Health Care Service Request form instead of in the Chronological Record of Medical Care, Youth Authority (YA) 8.263. Additionally, the psychologist did not put his/her title on the form.

- On two (50 percent) of the Chronological Records of Medical Care, the psychologists failed to indicate the time of the assessments.

- Three of the four (75 percent) Health Care Service Request forms that were in the UHRs were not reviewed or signed by the Resident Nurse (RN).

BACKGROUND

In December 2005 an audit report was prepared by the Office of the Inspector General (OIG) documenting a ward's request for mental health services through the Health Care Service Request form. On four different occasions while assigned to Preston Youth Correctional Facility (PYCF), a ward requested mental health services. The ward's requests started in October 2004 and concluded in December 2004. Despite numerous requests, the ward never received treatment. One of the requests contained documentation by staff that the ward did not want to be seen. Follow up was not indicated by a psychologist or psychiatrist.

In March 2005, the ward was transferred to NACYCF. There was no indication in the UHR that the ward requested mental health services on four separate occasions. The ward was classified as a low suicide risk. The ward was assigned to an intake hall and eventually transferred to a general population hall. The ward did not receive proper intervention from his earlier requests, while assigned to PYCF.

While the ward was assigned to NACYCF, there was no documentation that the ward continued to request mental health intervention. In July 2005, the ward's hall went on lock down due to a serious staff assault. In August 2005, the ward successfully committed suicide.

The CPRB determined that the procedures for requesting mental health intervention by way of the Health Care Service Request form should be reviewed. The review will help to ensure that all wards who request mental health services by submitting a Health Care Service Request form will receive treatment and the intervention will be documented.

The specific objectives of the review were to determine whether:

- The Health Care Service Request forms are being processed according to the I&C Manual, Revision IT-46, Section 6249.9;
- Health care staff is collecting the Health Care Service Request forms daily;
- Health Care Service Request forms are filed in the ward's UHR;
- Each form is signed and dated when they are collected, and entered on the Health Care Service Request Tracking Log, DJJ 8.017; and
- The RN reviews all requests including signing, dating, and placing the time in the designated areas.

The RN is prioritizing the requests by the following methods:

- Urgent requests shall be seen the day of the request;
- Routine requests shall be seen within one business day of the request; and
- Requests for mental health care may be referred to mental health services, if available within the time limits of urgent or routine priority.

Weekends and Holidays

- The health care staff is delivering all forms to the Outpatient Housing Unit (OHU) RN or designee on weekends and holidays after entering the form on the Health Care Service Request Tracking Log.

The OHU RN or designee shall:

- Review the form for mental health needs and establish priorities for each request on an urgent or routine basis;
- Sign, date, and time stamp the forms in the designated areas;
- Determine whether urgent conditions relating to mental health should be reported to the appropriate on site psychiatrist;
- The night before the next scheduled clinic, all routine requests shall be returned to the appropriate medical clinic for scheduling and to the appropriate mental health staff member for collection;
- Psychologists/Psychiatrists are providing treatment to the wards making the requests.(Revision IT-46 Section 6249.9);
- Psychologists/Psychiatrists are documenting in the UHR that appropriate care has been delivered. (I&C Manual, Section 6255); and
- Psychologists/Psychiatrists are completing a brief note including the date, signature and time stamp in the Chronological Record of Medical Care using the Subjective Objective Assessment Plan and Education (SOAPE). (I&C Manual, Section 6255).

The CPRB determined if the objectives were met by reviewing:

- The I&C Manual, Temporary Departmental Orders and the facilities operational manuals. The CPRB will be reviewing Revision # IT-46 and I&C Manual, Section, 6255;

- The audit report prepared by the OIG; Special Review into the Death of a Ward on August 31, 2005 at NACYCF, December 2005;

- Health Care Service Request forms concerning mental health;

- Health Care Service Request Tracking logs during the period of August 1 through January 23, 2007;

- UHRs;

- Information obtained from interviews of health care staff members; and

- The Ward Information Network (WIN) System data.

FINDINGS AND RECOMMENDATIONS

FINDING 1: 12 out of the 16 (75 percent) Health Care Service Request forms submitted had no documentation by clinical staff that the wards requesting services were evaluated.

After conducting interviews with staff, reviewing the WIN, and analyzing UHRs, the CPRB determined that wards who requested mental health services by submitting the Health Care Service Request form are not receiving treatment on a consistent basis.

A ward submitted three Health Care Service Request forms on the following dates: October 6, October 13, and October 23, 2007. There was an assessment documented in the Chronological Record of Medical Care that he was seen by a psychologist due to a self referral on November 15, 2007. It appeared the ward submitted multiple requests due to not receiving treatment initially, although a Health Care Service Request was not located in the UHR. The self referral note may have been generated by a Health Care Service Request that was misplaced and not in the UHR.

Some of the staff interviewed mentioned that some of the request forms are sitting in various staff's mailboxes or on their desks. When a psychologist goes on vacation, there is no back up psychologist coverage, so a form that is placed in their box, will not be viewed until the psychologist returns from vacation.

The CPRB determined that some of the Heath Care Service Request forms are lost. The twelve forms were noted on the Health Care Service Request Tracking Log, but there was no information on what occurred after the form was logged.

The CPRB concluded that there is no tracking or monitoring of mental health request forms once they are entered onto the Health Care Service Request Tracking Log.

Criteria:

Revision IT-46, I&C Manual, Section 6249.9: "Youth in the Division of Juvenile Justice shall have the daily opportunity to request and receive health care services (medical, dental and mental health). The health care services provided shall be based on medical necessity and the intervention required."

Recommendations:

Develop a tracking system to ensure wards who submit Health Care Service Request forms relating to mental health will be evaluated.

Develop a monthly monitoring system with the chief psychologist and the chief medical officer to ensure that wards requesting services are evaluated.

Provide formal training to all staff that receive mental health requests by way of the Health Care Service Request form.

FINDING 2: 12 out of 16 (75 percent) Health Care Service Request forms were not in the 9 UHRs.

The CPRB reviewed 9 UHRs and attempted to review 16 Health Care Service Request forms. 12 out of 16 request forms were not in the UHRs. This is a serious concern due to the lack of documentation and only 4 requests being available for review.

4 of the 16 (25 percent) Health Care Service Request forms were filed in the UHRs. Two of the four forms belonged to the same ward. The other two were individual wards.

The CPRB did not find 12 (75 percent) of the Health Care Service Request forms filed in the UHRs. There is not a designated procedure manual to instruct health care staff on who to provide the forms to once they enter the request on the Health Care Service Request Tracking log. As a result, the health care staff members are giving the forms to various psychologists and psychiatrists. Additionally, the forms are not tracked after they are placed in the Health Care Service Request Tracking log. Consequently, there are a number of missing forms.

The CPRB determined there is not consistent documentation of wards who are requesting mental health services by submitting a Health Care Service Request form. The forms are lost or are not being filed. If the forms are lost, a ward could be in crisis and never see a mental health professional due to his request being misplaced. As a result, the ward could successfully commit suicide or decompensate. If the form is not being filed, there is no documentation that the ward received the treatment he requested.

The CPRB determined, after interviewing various staff members, that all health care staff members need to be trained on how to process the Health Care Service Request forms.

Criteria:

I&C Manual, Revision IT-46, Section 6249.9, III Procedure, A, General Procedures (8): “All Health Care Service Request forms shall be filed in the UHR.”

Recommendations:

Develop clear procedures on how to handle mental health requests when a Health Care Service Request form is submitted.

Designate one senior psychologist who is responsible for triaging the mental health service requests.

Designate a back up person when the senior psychologist is on vacation or is off for an extended amount of time to triage the incoming request forms.

Develop a tracking system to ensure wards are receiving treatment when requesting mental health services by way of the Health Care Service Request form.

Place the original form in the UHR and place a copy of the form in the designated staff's box.

Provide formal training to all health care staff members.

FINDING 3: One of the four (25 percent) records of assessments completed by the psychologists was documented on the Health Care Service Request form instead of in the Chronological Record of Medical Care. In addition, the psychologist did not put his/her title on the document.

The CPRB determined that of the four records that contained mental health documentation one of the psychologists placed the documentation on the Health Care Service Request form instead of in the Chronological Record of Medical Care. The reviewer was able to discern that the documentation on the form was a psychologist due to the reviewer recognizing the name as a psychologist.

The documentation on the Chronological Record of Medical Care was unclear. Lack of documentation gives the impression that an assessment was not completed on the ward who requested mental health services by submitting a Health Care Service Request form.

The CPRB determined that NACYCF does not have a procedure in place regarding the processing and documenting of the assessment based on the Health Care Service Request form.

Criteria:

I&C Manual, Section 6255: "The UHR is the official and chronological record of mental health treatment. The UHR shall be used as the primary record to document that appropriate care has been delivered."

- Clinical health services staff shall complete a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care that draws attention to the filed document;
- Record changes in a ward's behavior, mental health status, mental health treatment, or program design in a timely fashion;
- Describe the problem and/or the present event, observations, clinical assessment, planned care, and anticipated results;
- Use the SOAPE format for recording, as outlined in the I&C Manual, Section 6169, UHR;
- Record summaries of individual interactions, group mental health interactions, and program progress; and
- Note the date and time of all UHR entries and sign above a printed name stamp.

Recommendations:

Provide training to all staff involved in the mental health component of the Health Care Service Request forms.

Establish procedures for recording documentation regarding Health Care Service Request forms that address mental health.

FINDING 4: On two of four (50 percent) Chronological Records of Medical Care, the psychologists failed to indicate the time of the assessment.

The CPRB found adequate documentation on the assessments generated by the request forms. However, two of the assessments did not include the time the assessments were completed.

The CPRB determined through various interviews with staff that the time entries are crucial in determining accurate documentation. For instance, if a ward is in crisis and made a suicidal gesture on the same day, but prior to the psychologist's assessment there would be no way to determine if the psychologist's assessment was before or after the suicidal gesture. Recording the time is necessary to provide accurate documentation of when the assessment was provided.

Criteria:

I&C Manual, Section 6255, states: "The UHR is the official and chronological record of mental health treatment. The UHR shall be used as the primary record to document that appropriate care has been delivered."

- Note the date and time of all UHR entries and sign above a printed name stamp.

Recommendation:

Provide training to all psychologists/psychiatrists to ensure compliance.

FINDING 5: Three of the four (75 percent) Health Care Service Request forms that were in the UHRs were not reviewed or signed by the RN.

The CPRB discovered four out of sixteen (25 percent) request forms in the UHRs. Twelve (75 percent) of the request forms were missing from the UHRs. CPRB was not able to determine if the RN reviewed and signed the request forms.

Interviews that were conducted with various health care staff indicate that the RN does not consistently review, sign, and date the Health Care Service Request forms that pertain to mental health concerns.

There was no documentation that the RN has been reviewing the Health Care Service Request forms. The health care technician retrieves the forms and enters the following information on the tracking log; ward's name, YA number, and date. The health record technician also enters the time and date of the form on the tracking log.

The RN is required to list the ward's medical complaint on the tracking log and designates the form to the appropriate health care service staff. If the RN is not reviewing the forms, they might not be routed to the appropriate person and the ward might not receive the appropriate treatment.

Criteria:

Collection and triage of Health Care Service Request forms. Revision IT-46, I&C Manual, Section 6249.9, B #3: "All requests shall be reviewed by an RN. The RN shall sign the forms and enter the date and time in the designated area."

Recommendation:

Provide formal training on the entire process of Health Care Service Request forms to all health care service staff members.

Review of Health Care Service Requests

N. A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
I&C Manual	Institution and Camps Branch Manual
NACYCF	N.A. Chaderjian Youth Correctional Facility
OHU	Outpatient Housing Unit
OIG	The Office of the Inspector General
PYCF	Preston Youth Correctional Facility
RN	Resident Nurse
SOAPE	Subjective Objective Assessment Plan and Education
UHR	Unified Health Record
WIN	Ward Information Network System
YA	Youth Authority

Information Security Compliance Review
N. A. Chaderjian Youth Correctional Facility
Exit Conference Discussion Notes
March 7, 2008

The Office of Audits and Compliance (OAC) Information Security Branch (ISB) conducted an Information Security Compliance Review of the N. A. Chaderjian Youth Correctional Facility (NACYCF) on February 25 through February 26, 2008. The review covered 7 different areas. The NACYCF was fully compliant in four areas, partially compliant in one area, and non-compliant in two areas. The overall score is 73 percent. The chart below details these outcomes.

FINDINGS SUMMARY:

		Score	Compliant	Partial Compliance	Non Compliant
STAFF COMPUTING ENVIRONMENT					
1.	Use Agreement (Form 1857) is on file.	53%			NC
2.	Annual Self-Certification of Information Security Awareness and Confidentiality forms are on file.	NA			
3.	Information security training is current.	NA			
4.	Staff log on are using own password.	100%	C		
5.	Network access authorization is on file.	90%	C		
6.	Physical locations of CPUs agree to inventory records.	79%		PC	
7.	Staff CPUs labeled “No Ward Access.”	4%			NC
8.	Staff monitors are not visible to inmates.	N/A			
9.	Anti virus updates are current.	92%	C		
10.	Security patches are current.	96%	C		
WARD COMPUTING ENVIRONMENT (Education, Library, Clerks)					
11.	Physical location of CPUs agrees to inventory records	N/A			
12.	CPU labeled as inmate computer.	N/A			
13.	Anti virus updates are current.	N/A			
14.	Inmate monitors are visible to supervisor.	N/A			
15.	Portable media is controlled.	N/A			
16.	Telecommunications access is restricted.	N/A			
17.	Operating system access is restricted.	N/A			
18.	Printer access is restricted.	N/A			
	Total of Tests	7	4	1	2
	Overall Percentage	**73%**			

Please Note:

1. Tests marked with “N/A” were not tested due to the differences between adult and youth policies. There are no youth policies for these tests, and therefore the tests were not performed.

2. The ward student-computing environment was not tested at this time.

Information Security Compliance Review
N. A. Chaderjian Youth Correctional Facility
Exit Conference Discussion Notes
March 7, 2008

OBJECTIVES, SCOPE AND METHODOLOGY

The objectives of the Information Security Compliance Review were to:

- Assess compliance to selected information security requirements,
- Evaluate other conditions discovered during the course of fieldwork that may jeopardize the security of information assets of the facility or of the Department, and
- Provide information security training for management and staff.

In conducting the fieldwork the ISB performed the following procedures:

- Interviewed senior management, information technology staff, institutional staff, and computer users.
- Asked staff to provide evidence that all authorized computer users had Acceptable Use Agreement forms on file.
- Tested selected information security attributes of users and IT equipment using three different population samples. This included both the staff and inmate computing environments.
- Reviewed various laws, policies and procedures, and other criteria related to information security in the custody environment.
- Conducted physical inspection of selected computers.
- Observed the activities of the information technology support staff.
- Analyzed the information gathered through the above processes and formulated conclusions.

FINDINGS AND RECOMMENDATIONS

The ISB provided a copy of our review guide to NACYCF IT staff. It contains criteria and detailed methodology. That information, therefore, is not duplicated under each finding.

ISB's findings and recommendations are listed below. ISB staff discussed them with management in an exit conference following our fieldwork. Please contact us if you would like to discuss further any of these issues.

Information Security Compliance Review
N. A. Chaderjian Youth Correctional Facility
Exit Conference Discussion Notes
March 7, 2008

1. **The Computing Technology Use Agreements (Form 1857) are not on file for all computer users. (53 percent compliance)**

   Recommendation: Require all users (staff and contractors) to complete a Form 1857 before being granted computer access.
   (DOM, Section 48010.8, 48010.8.2)
   (I & C, Section 1735)

2. **Physical locations of staff computers do not agree to inventory records. (79 percent compliance)**

   Recommendation: Maintain accurate inventory records. Evaluate procedures and resources used to maintain inventory records.
   (DOM, Section 46030.1, 49010.4)
   (I & C, Section 1720)

3. **Staff monitors and computers are not correctly labeled, "No Ward Access." (4 percent compliance)**

   Recommendation: Each computer in a facility shall be labeled to indicate whether or not inmate access is authorized.
   (TITLE 15 3041.3(d)), (DOM, Section 49020.18.3, 42020.6)
   (I & C, Section 1910 and 1540)

   Best Practice: Affix appropriate label to <u>both</u> the monitor and CPU.

State of California Department of Corrections and Rehabilitation

Memorandum

Date : April 25, 2008

To : Joan Loucraft
Assistant Superintendent
N.A. Chaderjian Youth Correctional Facility

Subject: **PRELIMINARY AUDIT REPORT OF THE PLANT OPERATIONS – N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY**

Attached is the Preliminary Audit Report of Findings and Recommendations developed during the audit of Plant Operations at N. A. Chaderjian Youth Correctional Facility (NACYCF). The Office of Audits and Compliance conducted fieldwork during the period of February 25 through March 6, 2008. A complete description of each finding is contained within the narrative portion of the report.

There are 16 findings and recommendations identified in the preliminary report categorized under the topics of Safety and Security, Health and Safety, Internal Control, Late Detection and Additional Workload, Policies and Procedures and Administrative Concerns.

Twelve of the findings are categorized under the Topics of Health and Safety and Policies and Procedures. For example, the Injury Illness and Preventive Program was last updated in 1994 and tool control procedure was last updated in 1997. Findings were discussed with Mr. R. Jaime, Chief of Plant Operations, who manages a Plant Operations Office that services a complex which consists of NACYCF and three other separate and distinct institutions.

During the audit, we attended a meeting, in which Mr. J. Akiyama, Staff Environmental Scientist, Department of Health Services (DHS), commented on the status of findings identified by the DHS in previous audits. He stated that the lack of compliance to previous recommendations borders on “willful negligence.” This concern was immediately elevated to California Department of Corrections and Rehabilitation management.

Please provide, within 30 days of receipt of the preliminary report, a brief description of your corrective action plan (CAP) for each finding and a date when you expect the finding to be resolved. A final report will be issued within 60 days after receipt of your CAP.

A follow-up audit will be scheduled within six to eight months. If you should have any specific questions, please contact René Francis at (916) 358-2070, or Michael Robinson at (916) 358-2793. For general information call me at (916) 358-2621.

RICHARD C. KRUPP, Ph.D.
Assistant Secretary
Office of Audits and Compliance

Attachment

cc: René Francis, Staff Management Auditor, OAC
Patricia Weatherspoon, OAC
George Valencia, OAC
Photographs of NCYCC's Main Kitchen

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
OFFICE OF AUDITS AND COMPLIANCE

REPORT OF FINDINGS AND RECOMMENDATIONS

PLANT OPERATIONS

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

FEBRUARY 25 THROUGH MARCH 6, 2008

CONDUCTED BY

AUDITS UNIT

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OFFICE OF AUDITS AND COMPLIANCE
AUDITS UNIT

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

INTRODUCTION

The California Department of Corrections and Rehabilitation (CDCR), Office of Audits and Compliance, conducted an audit of Plant Operations at N .A. Chaderjian Youth Correctional Facility (NACYCF). The purpose of the audit was to analyze and evaluate the level of compliance with State and departmental policies, procedures, rules, regulations, operational objectives, and guidelines. The following areas were audited within Plant Operations:

- Organizational Charts, Mission and Duty Statements;
- Policies and Procedures;
- Inspections of Facilities, Systems, and Reporting;
- Training Plans;
- Life, Health and Safety Management;
- Hazardous Material Handling;
- Tool Control;
- Communications/Performance Evaluation;
- Work Order and Reporting System;
- Preventive Maintenance; and
- Facility/Space Management.

The fieldwork was performed during the period of February 25 through March 6, 2008. The exit conference was held on March 13, 2008.

René Francis, Certified Government Financial Manager, supervised the audit. Michael Robinson, Associate Management Auditor, conducted the audit. Patricia Weatherspoon, Senior Management Auditor, provided second line supervision and review. George Valencia, Youth Administrator, and Richard C. Krupp, Assistant Secretary of the Office of Audits and Compliance, provided executive management oversight.

The audit consisted of an entrance conference, review of the prior reports, and test of transactions, interviews, observation, periodic management briefings, an exit conference, and issuance of the preliminary report.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS UNIT

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

AUDIT SCOPE

The scope of the audit encompasses the examination and evaluation of the adequacy and effectiveness of NACYCF's system of management control and compliance to applicable policies, procedures, rules, and regulations. The audit focused on current transactions but included prior transactions as deemed necessary. The control objectives include, but are not limited to, the following:

- State assets are safeguarded from unauthorized use or disposition;
- Transactions are executed in accordance to management's authorizations;
- Transactions are executed in accordance with applicable rules and regulations;
- Transactions are recorded correctly to permit the preparation of financial and management reports; and
- Programs are working efficiently and effectively.

In order to determine the adequacy of the control systems and level of compliance with State, Federal, and departmental fiscal procedures, the audit team performed the following audit procedures:

- Examined evidence on a test basis supporting management's assertions;
- Performed detailed analyses of documentation and transactions;
- Interviewed Facility staff;
- Made inspections and observations;
- Performed group discussions of the overall impact of deficiencies; and
- Discussed deficiencies with supervisors and management throughout the audit process.

SYMPTOMS OF CONTROL DEFICIENCIES

Experience has indicated that the existence of one or more of the following danger signals will usually be indicative of a poorly maintained or vulnerable control system. These symptoms may apply to the organization as a whole or to individual units or activities. Department heads and managers should identify and make the necessary corrections when warned by any of the danger signals listed below:

- Policy and procedural or operational manuals are either not currently maintained or are nonexistent;
- Lines of organizational authority and responsibility are not clearly articulated or are nonexistent;
- Financial and operational reporting is not timely and is not used as an effective management tool;
- Line supervisors ignore or do not adequately monitor control compliance;
- No procedures are established to assure that controls in all areas of operation are evaluated on a reasonable and timely basis;
- Internal control weaknesses detected are not acted upon in a timely fashion; and
- Controls and/or control evaluations bear little relationship to organizational exposure to risk of loss or resources.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS UNIT

N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

EXECUTIVE SUMMARY

The Audits Unit (AU) conducted an audit of the Plant Operations at N.A. Chaderjian Youth Correctional Facility (NACYCF) from February 25 through March 6, 2008. The purpose of the audit was to determine the level of compliance with State, Federal and departmental rules, regulations, policies, and procedures.

The exit conference was held on March 13, 2008. The AU requested that NACYCF provide a CAP 30 days after receipt of the preliminary report.

Areas audited:

- Organizational Charts, Mission and Duty Statements;
- Policies and Procedures;
- Inspections of Facilities, Systems, and Reporting;
- Training Plans;
- Life, Health, Safety Management;
- Hazardous Material Handling;
- Tool Control;
- Communications/Performance Evaluation;
- Work Order and Reporting System;
- Preventive Maintenance; and
- Facility/Space Management.

Sixteen findings are identified in this preliminary report and are categorized under the following topics:

Category	# of Findings	Page
Safety and Security	1	1
Health and Safety	4	2
Internal Control	1	5
Late Detection	1	6
Policy and Procedures	8	7
Administration Concerns	1	12
Total	**16**	

This summary provides the category, brief description of the findings and impact on the Institution.

I. SAFETY AND SECURITY

Tool Control

Control over tools is inadequate in accordance to the Department Operational Manual (DOM) and the California Code of Regulations (CCR), Title 15. We noted deficiencies at the paint, plumbing and engineers shop. For example, tool cages were inaccessible, tools were removed from the shadow boards with out the use of chits, twelve tools were unsecured at the paint shop and inventory sheets were not visible through the secured tool area in 4 of the 5 cages at the plumbing shop.
Impact: Late detection of theft and difficulty accounting for tools that have been issued.

II. HEALTH AND SAFETY

Safety Meetings

Safety meetings (i.e. tailgates) are not conducted for each maintenance section at least every 10 days and written minutes taken. This deficiency occurred at all shops tested. CCR, Title 8
Impact: Trades staff may not be aware of safety issues.

Hazardous Communication Program (HCP)

Plant Operations is not maintaining chemicals in accordance to the CCR, Title 8. For example, a daily perpetual chemical inventory is not conducted and Material Safety Data Sheets (MSDS) are not maintained for chemicals.
Impact: Late detection of missing chemicals and difficulties properly responding to a chemical breach.

Communicating Workplace Hazards

Staff is not supplied with access to current hazard information pertinent to their work assignments. For example, safety responsibilities are not reflected and delineated in each employee's duty statement as outlined in the IIPP.
Impact: Duties may not be performed in a safe and healthy manner.

Maintenance of Equipment/Structural Integrity of Food Service

Then following deficiencies were noted related to the condition of the Kitchen:

- The multi-sink heat sanitizing dishwashing machine is not operating in accordance with its specifications.
- The Chubco rotating oven is inoperable, and provides an excellent harborage area for rodents.
- Fifty percent of refrigeration/freezers in the main kitchen and 30 percent refrigerator/ freezers in the warehouse are inoperable.

- There are numerous holes in the walls and ice build up on the floors, doors, walls, condensers, fans and motors.
- Fifty percent of steam kettles in the production area and bakery are inoperable.
- There are a large number of damaged ceiling tiles.
- There are a large number of broken and missing floor tiles.
- New cooking equipment such as tilt skillets and an oven have been partially installed.

Impact: May result in difficulties accomplishing the objective of Food Services and contamination of food could occur.

III. INTERNAL CONTROL

Supervisors and Managers are not monitoring Plant Operations activities.
Impact: This condition could result in late detection of errors, irregularities and inefficient use of resources.

IV. LATE DETECTION AND ADDITIONAL WORKLOAD

Preventive Maintenance

Preventive maintenance is not performed and documented by Plant Operations. As a result, we could not locate historical asset data on the major systems, which includes mechanical and electrical equipment.
Impact: Late detection of equipment problems and additional cost due to repairs.

V. POLICIES AND PROCEDURES

Respiratory Protection Program

Plant Operations does not have a written Respiratory Protection Program in accordance with the CCR Title 8, and the General Industrial Safety Orders (GISO).
Impact: Employees may not be aware of specific work site procedures and elements for required respirator use.

Hearing Conservation

A hearing conservation program has not been implemented. As a result maintenance grounds keepers who use power tools do not wear hearing protection.
Impact: Prolonged exposure to high level of noise may diminish hearing or cause hearing loss.

Control of Dangerous and Toxic Substance

There is no current operating procedure regarding, the Control of Dangerous and Toxic Substances in accordance with DOM, Section 52030.
Impact: Employees may not be aware of policies and procedures related to toxic substances.

Contingency Plans

The Audit Unit could not determine if Plant Operations has a contingency plan for emergency equipment and supplies in accordance with the CCR, Title 15.
Impact: Difficult to respond to an emergency.

Injury Illness and Prevention Plan (IIPP)

The written IIPP program has not been updated and approved since 1994.
Impact: Employees may not be aware of current policies related to safety.

The Plant Operations Procedures Manual (POPM)

The POPM is not maintained. For example, the POPM does not promulgate current and/or applicable operational procedures (OP) and DOM supplements relative to the daily activities of Plant Operations.
Impact: Employees may not be aware of current policies and procedures related to plant operations and training may be difficult.

Work Order System

The Superintendents of NACYCF, Dewitt Nelson Youth Correctional Facility (DWNYCF), O.H. Close Youth Correctional Facility (OHCYCF) and Northern California Youth Correctional Center (NCYCC) have not established and or approved an Operational Procedure (OP) for the work order system (work request and work orders) that affects the entire complex of institutions that Plant Operations services. The local operating procedure should establish guidelines for an orderly and standard method of processing and accomplishing the services requested of the Plant Operations.
Impact: This issue could result in inefficiencies and disorganization.

Pest Control

There are no local operating procedures for the pest control technician. The operating procedure should promulgate the purpose, approval and review, regulatory oversight, notifications, and a facility process to track the usage of all structural pesticides, etc.
Impact: The Pest Control program may not be properly administered.

VI. ADMINISTRATIVE CONCERNS

Operational Reporting

Operational reporting is not timely and used as an effective management tool. In addition, line supervisors do not adequately monitor and act upon weaknesses in a timely manner.
Impact: This issue may result in late detection of problems and inefficiencies.

Monitoring Activities

Supervisors and Managers are not monitoring Plant Operations activities. For example, the work request and work order process is inefficient, reports are not reviewed, policies are not updated, a PM program has not been established, and an effective IIPP is not in place.
Impact: This condition could result in late detection of errors, irregularities and inefficient use of resources. Additionally, plant operations staff may not perform task in a safe manner.

FINDINGS AND RECOMMENDATIONS

I. SAFETY AND SECURITY

A. Tool Control

Control over tools is inadequate in accordance to the DOM and the CCR Title 15. We noted the following deficiencies at the paint, plumbing and engineers shop.

- Tool cages could not be accessed by the auditor and the supervising escort to reconcile inventory.
- Tools were removed from the shadow boards without the use of chits.
- Tools were not always maintained inside a secure cage. We noted 12 tools lying on a cabinet at the paint shop.
- Inventory sheets were not visible through the secured tool area in four of the five cages at the plumbing shop.

This issue could result in late detection of missing tools.

DOM, Chapter 5000, Sub-chapter 5200, Tool Storage, "Pursuant to the Penal Code the director has established a system for uniform tool control and prevention of unauthorized or improper use of tools . . . Supervisors and managers shall monitor the control and inventory in their respective department /area/unit . . . Each storage area shall include an inventory card for any custody to determine an immediate and accurate count of the tools . . . Inventory listing shall be kept for all tools . . . Critical Tools include all tools that are extremely dangerous (i.e., ropes and ladders over six feet in height)." DOM 52040.8, Inventories Daily, states in part, "The supervisor shall maintain a master tool inventory which shall be secured and not available to inmates...." CCR, Title 15, Section 3303 states in part, "Institution heads shall maintain procedures for controlling the following safety and security hazards within facilities…Control of tools".

RECOMMENDATION

Ensure that controls over tools are adequate. Annually review, update, and adhere to the Tool Control Procedures.

II. HEALTH AND SAFETY

A. Safety Meetings

Safety meetings (i.e, tailgates) are not conducted for each maintenance section at least every 10 days and written minutes taken. One hundred percent of the shops tested did not conduct and document consistent safety meetings in accordance to the CCR, Title 8.

This issue could result in trade staff not performing their duties in a safe manner.

CCR, Title 8, Article 3, Section 8406(e) IIPP states in part, "Supervisory personnel shall conduct "toolbox" or "tailgate" safety meetings with their crews at least weekly on the job to emphasize safety. A record of such meetings shall be kept, stating the meeting date, time, place, supervisory personnel present subjects discussed and corrective action taken, if any, and maintained for inspection."

RECOMMENDATION

Adhere to the CCR, Title 8, by conducting tailgate meetings and documenting the contents of the meetings.

B. HCP

The following deficiencies related to HCP occurred at the HCP paint, engineers and plumbing shops:

- MSDS are not maintained for chemicals that are stored and used.
- A daily perpetual chemical inventory is not conducted.
- The hazardous materials program is not monitored by the Chief of Plant and supervisors.
- Policies and procedures do not exist communicating to employees what should be done when they encounter or identify hazardous materials such as asbestos and Polychlorinated Biphenyls (PCB), etc.

This issue could result in an increased threat to life, health and safety, and gives the appearance that an effective IIPP has not been implemented.

DOM ARTICLE 17 — CONTROL OF DANGEROUS AND TOXIC SUBSTANCES, Section 52030.1, states, "All units of the Department shall meet or exceed the requirements of all rules, regulations and laws applicable to identification, training, use, storage, handling and disposal of hazardous, toxic, volatile, caustic and flammable substances; including those established in the guidelines for the control and use of flammable, toxic and caustic substances, and the Hazardous Substances Information and Training Act, LC, Division 5, Chapter 2.5. The department shall provide a working and living area that is as free as possible from unsafe and unhealthy exposure which could lead to personal injury or illness…." DOM, Section 52030.2 states, "This procedure shall establish a method for the identification, receipt, training, issue,

handling (or use), inventory and disposal of hazardous substances, which is in compliance with all federal, state and local laws or ordinances." DOM, Section 52030.4.1 states in part, "Maintain a constant daily inventory of all hazardous substances used or stored…." The CCR, Title 8, Section 5194, HCP states in part, "Department heads shall monitor daily compliance with this procedure in the areas of their responsibility….Each area supervisor shall ensure that every person required to work with or use hazardous, toxic, volatile substances is appropriately trained." CCR, Title 15, 3303 (b) states in part, "Institution heads shall maintain procedures for controlling the following safety and security hazards within the facility: Control of harmful physical agents and toxic or hazardous substances."

RECOMMENDATION

Adhere and comply with the CCR, Title 8, Title 15, and the DOM by establishing a Hazard Communication Program.

C. Communicating Work Place Hazards

Communicating work place hazards is not performed in accordance to the NCYCC IIPP. Staff is not supplied with access to current hazard information pertinent to their work assignments. We noted the following:

- The written IIPP program has not been updated and approved since 1994.
- Safety responsibilities are not reflected and delineated in each employee's duty statement as outlined in the IIPP.

This issue may result in duties not being performed in a safe and healthy manner.

Statement of Management Commitment states, **"I**t is the policy of the NCYCC that the health and safety of employees, volunteers, wards and visitors will be given priority over all other operations and activities." Section B, "C" states, "safety responsibilities are reflected and delineated in each employee's duty statement. Job descriptions include task, performed, tools required, material and equipment used…." "F" states in part, "Codes of Safe Practices are used to establish safe work rules for a particular job classification." (Reference: CCR, Title 8 sections 1669-1672)

RECOMMENDATION

Adhere to the NYCC, IIPP program.

D. Maintenance of Equipment/ Structural Integrity of Food Services

We noted the following deficiencies:

- The multi-sink heat sanitizing dishwashing machine is not operating in accordance with its specifications.

- The rotating Chubco oven is inoperable and provides an excellent harborage area for rodents
- Fifty percent of refrigeration/freezers in the main kitchen and 30 percent of refrigerator/ freezers in the warehouse are inoperable. Refrigeration/ freezer space that is in operable may cross contaminate food (chemically, biologically and mechanically) because of peeling paint, exposed wires, protruding metal plates and inadequate temperatures. In addition, there are numerous holes in the walls and ice build up on the floors, doors, walls, condensers, fans and motors.
- Fifty percent of steam kettles in the production area and bakery are inoperable.
- There are a large number of damaged ceiling tiles.
- There are a large number of broken and missing floor tiles.
- New cooking equipment such as tilt skillets and an oven have been partially installed.

As a result of theses issues, the facility's ability to produce food with a high degree of food safety and staff efficiency is significantly reduced.

The California Department of Health Services (DHS) Environmental Health Surveys 2005 through 2007 states in part, "An inadequate level of plant maintenance staffing throughout the facility hinders corrective action in a timely manner. Sufficient levels of plant maintenance staff is essential to maintain, repair, or replace equipment, deteriorating surfaces, deteriorating utilities such as water lines, sewer lines, and steam lines and maintain the structure in good repair. The inability to maintain a full complement of plant maintenance staff over a number of years has resulted in a preventive maintenance program that is nonfunctional. Food services and plant operations projects that have been developed during the past several years to correct many of the current problems have not been adequately funded to ensure that the facility operates as designed. A significant number of walk in refrigerator and freezers are inoperative."

RECOMMENDATION

Assess equipment needs and structural damage and continue to request funding to repair/replace equipment and maintain structural integrity.

III. INTERNAL CONTROL

Monitoring Activities

Supervisors and Managers are not monitoring Plant Operations activities. For example,

- The work request and work order process is inefficient.
- Reports are not completed and reviewed.
- Policies and procedures are not updated.
- A viable PM program is not maintained.
- Adequate documentation of the IIPP is not maintained.

This condition could result in late detection of errors, irregularities and inefficient use of resources.

SAM Section 20050, Internal Controls, states in part that, “Line supervisors should adequately monitor control compliance.”

RECOMMENDATION

Monitor Plant Operations activities by performing the task listed above among other responsibilities.

IV. LATE DETECTION AND ADDITIONAL WORKLOAD

A. Preventive Maintenance

The systematic servicing, inspection and prevention of failure and abuse of facilities and equipment is not performed by Plant Operations. The process includes the proper care, use, operation, cleaning, preservation and lubrication of the facilities and equipment as well as inspection, adjustment and, minor repairs. Also, parts should be replaced as necessary to eliminate incipient difficulties becoming major. We could not locate historical asset data on the four facilities major systems as follows:

Mechanical Equipment
Heating/ventilating air handlers
Supply and return air fans
Air conditioning systems (compressors, condensers, coils and fans)
Cooling towers
Package air conditioning units
Unit ventilators and fan coil-units
Circulating pumps
Condensate return pumps
Lift and sump pumps
Unit pumps
Steam/hot water converters
Domestic water heaters
Air compressors
Vacuum pumps
Refrigeration
Boilers
Water Treatment systems

Electrical Equipment
Transformers
Switchgear
Motor control centers
Panel Boards (power, lighting)
Motor starters
Motors (as part of other units)
Emergency generators
Communication equipment
Alarm systems

This issue decreases efficiency, increases downtime, and results in additional cost due to repairs and makes decision-making difficult.

NCYCC IIPP section D-I states, “The Preventive Maintenance system is an integral part of the Safety and Health Improvement Program at the NCYCC. Ongoing monitoring and evaluation activities are the primary assessment tools utilized in the overall management of this program. As in other aspects of this program, monitoring and

reporting occurs on an ongoing basis. Compliance with Preventive Maintenance work orders for all parts of the utilities management program are monitored, including the electrical distribution system, emergency power, vertical and horizontal transport, HVAC system, plumbing, and communication systems(both radio/telephone and security. DPOMPM, I-A states in part" Wardens/Superintendents are responsible for the development and implementation of a written preventive maintenance plan based on the guideline provided by Facilities Maintenance … Overall responsibility for the operation of this procedure shall be with the Correctional Administrator, Business Services, with functional responsibility delegated to the Chief of Plant Operations…

RECOMMENDATION

Establish the systematic maintenance of all major institutional facilities and equipment.

V. POLICIES AND PROCEDURES

A. Respiratory Protection Program

Plant Operations does not have a written Respiratory Program in accordance with the CCR, Title 8, Section 5144 and the General Industrial Safety Orders (GISO). The written respiratory program identifies, evaluates and controls the exposure to respiratory hazards. In addition, it will establish the proper respiratory training and fit testing including record keeping and tracking.

This issue could result in exposure to respiratory hazards.

Subchapter 7. General Industry Safety Orders, Group 16. Control of Hazardous Substances, Article 107. Dusts, Fumes, Mists, Vapors and Gases (c) Respiratory protection program. This subsection requires the employer to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use. The program must be administered by a suitably trained program administrator. In addition, certain program elements may be required for voluntary use to prevent potential hazards associated with the use of the respirator. The Small Entity Compliance Guide contains criteria for the selection of a program administrator and a sample program that meets the requirements of this subsection.

RECOMMENDATION

Adhere and comply with the California Code of Regulations and develop a written respiratory program.

B. Hearing Conservation

A hearing conservation program has not been implemented. We noted high levels of noise when the maintenance grounds keepers used power tools (i.e., leaf blowers and tractor mowers) without hearing protection. In addition, a procedure for hearing protection has not been developed or approved.

Prolonged exposure to high level of noise may diminish hearing or cause hearing loss.

CCR, Title 8 Section 3023, Personal Protective Equipment and Section 5097, Hearing Conservation Program states in part that, “appropriate hearing protection shall be provided to employees who may be subjected to a hazardous environmental condition.” Cal/OSHA regulations requires at 85 db (8 hr TWA) = Hearing Conservation Program to train employees, make hearing protection available, sample for noise levels, do hearing tests and finally notify employees of the results.

RECOMMENDATION

Establish and implement a hearing conservation program.

C. Control of Dangerous and Toxic Substances

There is no current operating procedure regarding the Control of Dangerous and Toxic Substances (i.e., DOM, Section 52030).

This issue could result in difficulties complying to current policies and procedures related to chemical control.

CCR, Title 15 sub-chapter 5, Article 1, 3380(C), states in part, “Subject to the approval of the Wardens, Superintendents and Parole Region Administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations…such procedures will apply only to the inmates, parolees, and personnel under the administrator.”

RECOMMENDATION

Develop an operational procedure for the control of dangerous and toxic substances.

D. Contingency Plans

The AU could not determine if Plant Operations has a contingency plan for emergency equipment and supplies in accordance to the CCR, Title 15. The plan in part would disclose the role of Plant Operations in case of a disaster or emergency.

This condition is not in accordance with the CCR, Title 15, article 4 Disorders and Emergencies.

CCR, Title 15, Section 3301. Disturbance Control Plan, states that, “Each warden or superintendent must have in effect at all times a plan, approved by the director, for meeting emergencies, such as riots, strikes, attacks upon inmates, visitors or staff, explosions or fires, suicides or attempted suicides, and accidental injuries to inmates or visitors or employees. This plan must include procedures for requesting assistance from outside the institution when circumstances warrant.” Comment: Former DP-4402, disturbance control plan.

CCR, Title 15 Section 3302. Emergency Preparedness Plan:

(a) Each warden and superintendent must have in effect at all times a plan approved by the director for meeting emergencies delineated and required by the California Emergency Services Act of 1970.
(b) This plan will include, as a minimum, emergency measures to be taken to prepare for and respond to the following types of emergency situations:

    (1) War
    (2) Earthquakes
    (3) Seismic sea waves
    (4) Flood
    (5) Fire
    (6) Civil Disturbances

(7) Accident, transportation-industrial
(8) Pollution.

(c) A separate Employee Protection Plan will be developed in accordance with the California Emergency Services Act. Two copies of this plan will be attached to the emergency preparedness plan when that plan is submitted to the director for approval.

(d) Emergency preparedness plans and the employee protection plan will be revised and updated by the warden or superintendent and be submitted to the director for approval biennially.

RECOMMENDATION:

Develop an emergency preparedness plan in compliance to the CCR.

E. IIPP

The written IIPP program has not been updated and approved since 1994.

This issue could result in difficulties complying with current Rules and Regulations relative to IIPP.

CCR, Title 15 sub-chapter 5, Article 1, Section 3380(C), "Subject to the approval of the Wardens, Superintendents and Parole Region Administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations…such procedures will apply only to the inmates, parolees, and personnel under the administrator."

RECOMMENDATION:

Update the IIPP.

F. POPM

The POPM is not current. For example, it does not promulgate current and/or applicable Operational Procedures (OP) and DOM supplements relative to the daily activities of Plant Operations. The AU noted the following:

- There is no mission statement outlining the goals and objectives of the Plant Operations.
- Tool Control Procedures were last updated in 1997 and have not been approved by chiefs of security or superintendents in the four facilities that plant operations performs maintenance.
- The procedure outlining the storage, use, and disposal of toxic materials is not current, and has no established date and approval by superintendents.
- The procedure for lock-out tag-out has no established date and approval by superintendents.
- There is no Preventive Maintenance Section.

- There is no pest control abatement procedure which outlines notification to staff and wards when structural pesticides are applied.
- Work order request procedures were last updated in 2001.
- The POPM includes duplicative directives which may make training on institutional protocol difficult.

This issue results in non current OPs, processes may not be standardized and a vulnerable control system maybe in place.

DOM, Article 6, Section 1200 states in part, “regulations, manuals, and bulletins utilized to transmit departmental directives and establishes procedures for their promulgation, distribution and maintenance.” SAM, Section 20050 states in part, “Experience has indicated that the existence of the following danger signal will usually indicate a poorly maintained and vulnerable control system…. Policy and procedural or operational manuals are either not currently maintained or are non-existent.”

RECOMMENDATION

Maintain a current viable POPM.

G. Work Order System

The Superintendents of NACYCF, DWNYCF, OHCYCF and NCYCC have not established and/or approved an OP for the work order system (work request and work orders) that affects the entire complex of institutions. The local operating procedure should establish guidelines for an orderly and standard method of processing and accomplishing the services requested of the Plant Operations.

This issue results in an inefficient method for requesting work from the Plant Operations.

CCR, Title 15 sub-chapter 5, Article 1 3380(C), “Subject to the approval of the Wardens, Superintendents and Parole Region Administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations…such procedures will apply only to the inmates, parolees, and personnel under the administrator.”

RECOMMENDATION

Obtain approvals as established by the CCR. Create and maintain a viable work request and work order procedure

F. Pest Control

There are no local operating procedures for the pest control technician. The operating procedure should promulgate the purpose, approval and review, regulatory oversight and notifications and a facility process to track the usage of all structural pesticides etc.

We noted that an inoperable Chubco oven provides an excellent harborage for rodents. This condition was also noted by DHS.

Also, insect and rodent activity is prevalent in the main kitchen. Doors and gates are not modified to be vermin proof.

This issue may result in food contamination.

CCR, Title 15, Subchapter 5 Article 1, Section 3380(c), "Subject to the approval of the Wardens, Superintendents and parole Region Administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations…. Such procedures will apply only to the inmates, parolees, and personnel under the administrator." Bargaining Unit 1 Agreement, Section 10.28 which states, "whenever a department utilizes a pest control chemical in a state owned or managed building/grounds, the department will provide at least forty-eight hours notice prior to application of the chemical, unless an infestation occurs which requires immediate action. Notices will be posted in the lobby building and will be disseminated to building tenant contacts. The Department of Health Services Environmental Health Survey states "The unused Chubco rotary oven in the kitchen provides excellent harborage area for rodents…. The rotary oven should be removed to eliminate a rodent harborage that is within the kitchen."

RECOMMENDATION

Develop a local operating procedure for the Pest Control Technician. Also, remove the Chubco rotary oven as recommended by the Department of Health Services, if unable to resolve rodent activity.

VI. ADMINISTRATIVE CONCERNS

A. Operational Reporting

Operational reporting is not timely and used as an effective management tool. In addition, line supervisors do not adequately monitor and act upon weaknesses in a timely manner. For example,

- The total hours used to maintain the physical plant is not documented.
- The operational maintenance report has not been completed or forwarded to management since July 2007.
- Priorities are not established in accordance with departmental guidelines.
- The Chief of Plant Operations or his/her designee does not inspect and document inspections on a regular basis. Examples include a hazard checklist for grounds and a hazard checklist for buildings.
- The Chief of Plant Operations or key staff is not assigned to a facility wide committee that has an impact on maintenance and other plant responsibilities such as a space utilization committee.
- Time and materials are not documented on completed work orders.

This practice may result in inefficiencies and inaccurate reports provided to institutional management and Central Office Maintenance Unit.

DOM, Section 11010.12.4.4, Security Operations and Management Branch, Facilities Maintenance Unit, states in part, “Evaluate monthly corrective and preventive maintenance reports by facility. Compile information from the monthly reports as appropriate for the Regional Administrators and Deputy Director. DOM, Article 3 Standing Committees 11030.1 Policy Standing Committees are established by the director as necessary, to facilitate the accomplishment of department goals and objectives within the department.” CCR, Title 15, 1280 states, “The facility administrator shall develop written policies and procedures for the maintenance of an acceptable level of cleanliness, repair and safety throughout the facility. Such a plan shall provide for a regular schedule of house keeping task and inspections to identify and correct unsanitary or unsafe conditions or work practices which may be found.”

RECOMMENDATION

Track and monitor plant operations activities by establishing inspections schedules, developing meaningful reports, prioritizing work orders and participating on committee as necessary given the needs of the complex.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS UNIT
N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

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GLOSSARY

CAP	Corrective Action Plan
CCR	California Code of Regulations
CDCR	California Department of Corrections and Rehabilitation
CE	Chief Engineer
CF	Correctional Facility
CPM	Correctional Plant Manager
CPS	Correctional Plant Supervisor
DJJ	Division of Juvenile Justice
DOC	Date of Completion
DOM	Department Operations Manual
DPOMPM	Departmental Plant Operation Maintenance Procedures Manual
ECP	Exposure Control Plan
FC	Facility Center
GC	Government Code
GISO	General Industrial Safety Orders
HCP	Hazardous Communication Program
HQ	Headquarters
HSC	Health and Safety Code
HVAC	Heating Ventilation and Air Conditioning
HWMP	Hazardous Waste Management Program
IIPP	Illness and Injury Prevention Program
IMU	Institution Maintenance Unit
IST	In-Service Training
MOU	Memorandum of Understanding
MSDS	Material Safety Data Sheet
NCYCC	Northern California Youth Correctional Center
OP	Operational Procedure
PM	Preventive Maintenance
POM	Plant Operations Maintenance
POPM	Plant Operations Procedures Manual
SAM	State Administrative Manual
SAPMS	Standard Automated Preventive Maintenance System
SBT	Supervisor of Building Trades

COMPLIANCE PEER REVIEW

N. A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary

February 2008

USE OF FORCE

Division of Juvenile Justice, Temporary Departmental Order #06-73, Sections 2080-2107 - Use of Force

Office of Audits and Compliance Staff
Gil DeLyon, Captain

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ) Temporary Departmental Order (TDO) 06-73, Sections 2080-2107, to determine if N. A. Chaderjian Youth Correctional Facility (NACYCF) is in compliance with the policy that identifies clearly the peace officer responsibilities for applying force, reporting force, and reporting excessive and/or, unnecessary force.

The review period for staff use of force (UOF) inquiries was January 1 through December 31, 2007. During this period, the CPRB reviewed the UOF database and determined that NACYCF had 11 staff inquiries relating to UOF. The CPRB selected all 11 inquiries to be included in the review. The review period for the Institutional Force Review Committee (IFRC) reports was June through December 2007. The CPRB identified a sample of 100 IFRC reports and as a result, the CPRB provided a critical analysis of 10 percent of the reports to be included in the review. The following were the findings:

The CPRB determined that NACYCF is not in compliance with TDO 06-73, Section 2107.

- NACYCF is not requesting a 30-day Inquiry Time Extension from the Division of Juvenile Facilities for staff inquiries that exceed 30 working days.

The CPRB determined that NACYCF is in compliance with TDO 06-73, Sections 2085, 2102, and 2106.

- 7 out of 10 (70 percent) UOF packets, at the IFRC level, were completed within departmental time frames. It should be noted, the risk management position was vacant for one month which resulted in three UOF packets from September through November exceeding departmental time frames.

- The IFRC meets on a weekly basis to review all completed UOF incidents.

- NACYCF maintains a database to track all UOF reports and inquiries.

- 9 out of 11 (82 percent) staff UOF inquiries were completed within the 30-day time frame.

BACKGROUND

The CPRB met with the DJJ on January 8, 2008, to discuss areas of high risk. UOF was identified as a high risk area, due to both past litigation and court mandates. Therefore, based on risk factor, the CPRB determined that UOF would be the topic of review. The review will help to ensure that all time frames are met and the UOF reports are accurately documented.

The specific objectives of the review were to determine whether:

- UOF is reviewed at a supervisory and managerial level, and the IFRC is meeting on a monthly basis. (TDO 06-73, Section 2085).

- Time frames have been met regarding all applicable reports, clarifications, and forms pertaining to the UOF report package. (TDO 06-73, Section 2102).

    a. Captain/Major – Normally within 2 business days of receipt.

    b. Superintendent - Normally within 2 business days of receipt.

    c. IFRC – To review within 30 days.

    d. Departmental Force Review Committee.

    e. Bureau of Independent Review.

- The use of force reports are maintained in a database and the length of time the reports are retained. (TDO 06-73, Section 2106).

- All inquiries regarding allegations of excessive or unnecessary force are assessed (no action needed, conduct an inquiry, or recommend a formal Internal Affairs investigation), and the reports are completed within the required time frames. Additionally, when an inquiry is not concluded in 30-days, the superintendent/site administrator shall request a 30-day extension through the chain of command to the Director of the Division of Juvenile Facilities. (TDO 06-73, Section 2107).

FINDINGS AND RECOMMENDATIONS

FINDING 1: NACYCF is not requesting a 30-day Inquiry Time Extension from the Division of Juvenile Facilities for staff inquiries that exceed 30 working days.

The Division of Juvenile Facilities does not have staff assigned to track and/or approve a facilities 30-day Inquiry Time Extension request.

To determine NACYCF's UOF process, the CPRB conducted several interviews with management and the risk management coordinator during the period of February 26 through 27, 2008. From the interviews, it was determined that NACYCF does not request a 30-day Inquiry Time Extension from the Director of the Division of Juvenile Facilities.

According to DJJ's UOF coordinator, the facilities are required to forward the 30-day Inquiry Time Extension requests to DJJ. However, DJJ does not have staff assigned to receive, track and/or approve any time extension requests received from the youth facilities.

Criteria:

TDO# 06-73, Section 2107: Reporting allegations of unnecessary or excessive force, states in part: "All inquiries shall be completed within 30 working days of the superintendent's review of the complaint/report of misconduct," and "If and when an inquiry is not concluded in 30-days, the superintendent/site administrator shall request a 30-day Inquiry Time Extension through the chain of command to the Director of the Division of Juvenile Facilities."

Recommendation:

Immediately clear any outstanding staff inquiries.

Provide staff to track the facilities 30-Day Inquiry Time Extension requests.

Amend current policy or put temporary controls in place until policy can be amended.

Review of Security Operations

N. A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
DFRC	Departmental Force Review Committee
IFRC	Institutional Force Review Committee
NACYCF	N.A. Chaderjian Youth Correctional Facility
TDO	Temporary Departmental Order
UOF	Use of Force